Inpatient palliative care improves care quality and family satisfaction

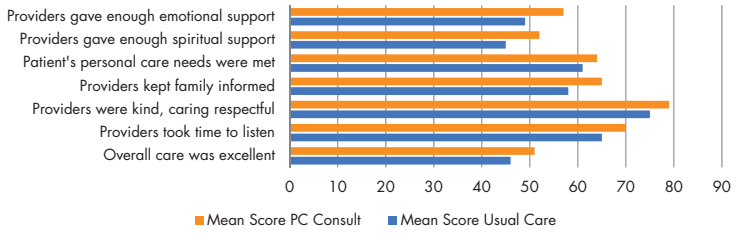
Hospitalized patients with serious illness, and their families, commonly have a wide range of needs, including management of pain and other symptoms; assistance with emotional and spiritual distress; help understanding complex medical information addressing disease processes, prognosis and the benefits and burdens of various treatment options; and assistance in developing and assuring adherence to care plans that are aligned with their goals and preferences. A growing body of evidence has shown that inpatient palliative care services (PCS) can help with many of these needs.

In a study by Casarett et al., telephone surveys were conducted with over 500 family members of veterans who received care from a Department of Veterans Affairs medical facility in the last month of life.[1] Adjusted findings showed that **compared to families of patients who received usual care, families of palliative care patients rated the care their loved-one received more highly in multiple areas**, including **information and communication, emotional and spiritual support, care around the time of death, well-being and dignity, and care concordance with patient preferences** (all significant at p<0.001).

In another study that sought input from family members of deceased patients, Casarett et al. found that as compared to families of patients who received usual care, **families of patients cared for by palliative care teams were significantly more likely to report that patient's care in the last month of life was "excellent"** (51% vs 46%; odds ratio 1.25; p=0.04).[2]

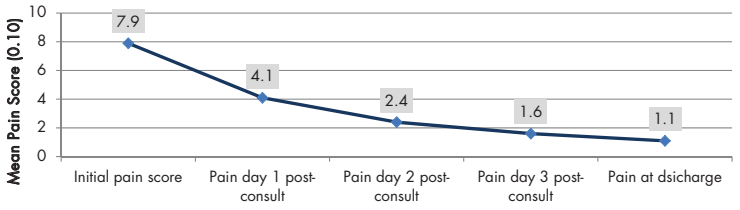
Families of patients who received palliative care also reported higher satisfaction with multiple elements of care, compared to families of patients who received usual care.

Family Rating of Care Quality Palliative Care Compared to Usual Care[2]



Inpatient PC can also help with symptom management. In a retrospective analysis of the impact of a PC service at a large urban hospital, Ciemens et al. found that **PC consultation had an impressive impact on clinical outcomes, with an observed reduction in pain, dyspnea, and secretions scores of 86%, 64%, and 87%**, respectively, among consultation patients.[3]

Change in Pain Scores Following PC Consultation[3]



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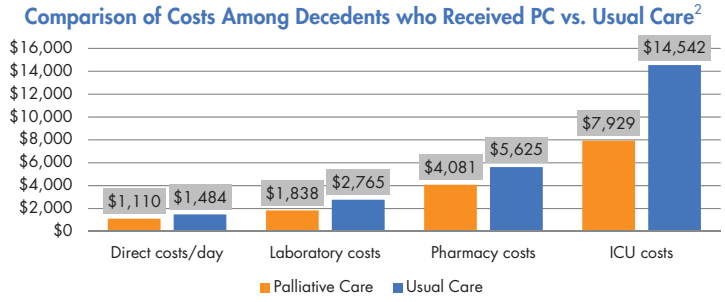
Inpatient palliative care reduces hospital costs

Inpatient palliative care services (PCS) play an important role in providing quality, efficient care to seriously-ill hospitalized patients. A key PCS function is to work with patients and families to clarify goals of care. At times these discussions result in the patient and family deciding to forego invasive care in favor of care focused on managing symptoms and improving quality of life. This change in treatment focus can lead to transfer out of the intensive care unit (ICU), discontinuing non-beneficial treatments, and adding state-of-the-art symptom management to better control pain, dyspnea, and other symptoms that cause suffering and distress. These changes in the goals and course of care can lead to significant reductions in hospital costs.

A recent review of 10 rigorous studies that examined the economic impact of PCS found that such services reduce hospital costs by 9–25%.[1] For example, in randomized trial of inpatient interdisciplinary PC consultation vs. usual care for hospitalized, seriously-ill patients, Gade and colleagues found that **those who received PC had significantly fewer readmissions that featured ICU days** (p=0.04) and longer median hospice stays (24 days v 12 days; p=0.04).[2] Investigators found that after backing out the cost of the PC intervention, **patients who received PC had 6-month health care costs that were $4,855 lower per patient**, compared to costs for patients who received usual care (p=0.001).

Evidence of PCS impact on hospital costs was also seen in a study conducted at 8 hospitals with mature PC services.[2] Morrison et al. found that among **patients who received PC consultation who were discharged alive, direct costs were $1,696 lower per admission** (p=0.004) compared to costs for



matched usual care patients. **Among PC patients who died, direct costs were $4,908 lower** (p=0.003). Savings reflected significant reductions in pharmacy, laboratory, and intensive care unit costs in the period following consultation.

PCS impact on utilization and costs crosses patient populations and payers. Morrison et al. used propensity score matching to assess outcomes among Medicaid beneficiaries who did and did not receive PC consultation during an inpatient admission.[3] The authors found that **Medicaid patients who received PC spent an average of 3.6 fewer days in intensive care beds**, compared with patients who received usual care (p=0.04). Further, **patients who received PC and died in the hospital were significantly less likely than patients who received usual care to do so while in intensive care** (34% vs. 58%; p=0.04). **PC patients who were discharged alive were significantly more likely to be discharged to hospice care** (30% vs. 1%; p<0.001). **Medicaid patients who received PC averaged $6,900 less in total hospital costs during a given admission** compared to costs for a matched group of patients who received usual care. Avoided costs averaged $4,098 per admission for patients discharged alive, and $7,563 for patients who died in the hospital.

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