



Research Into Practice: Building Bridges, Effecting Change



Collaborative Vision and

Mission:

CAPC+NPCRC



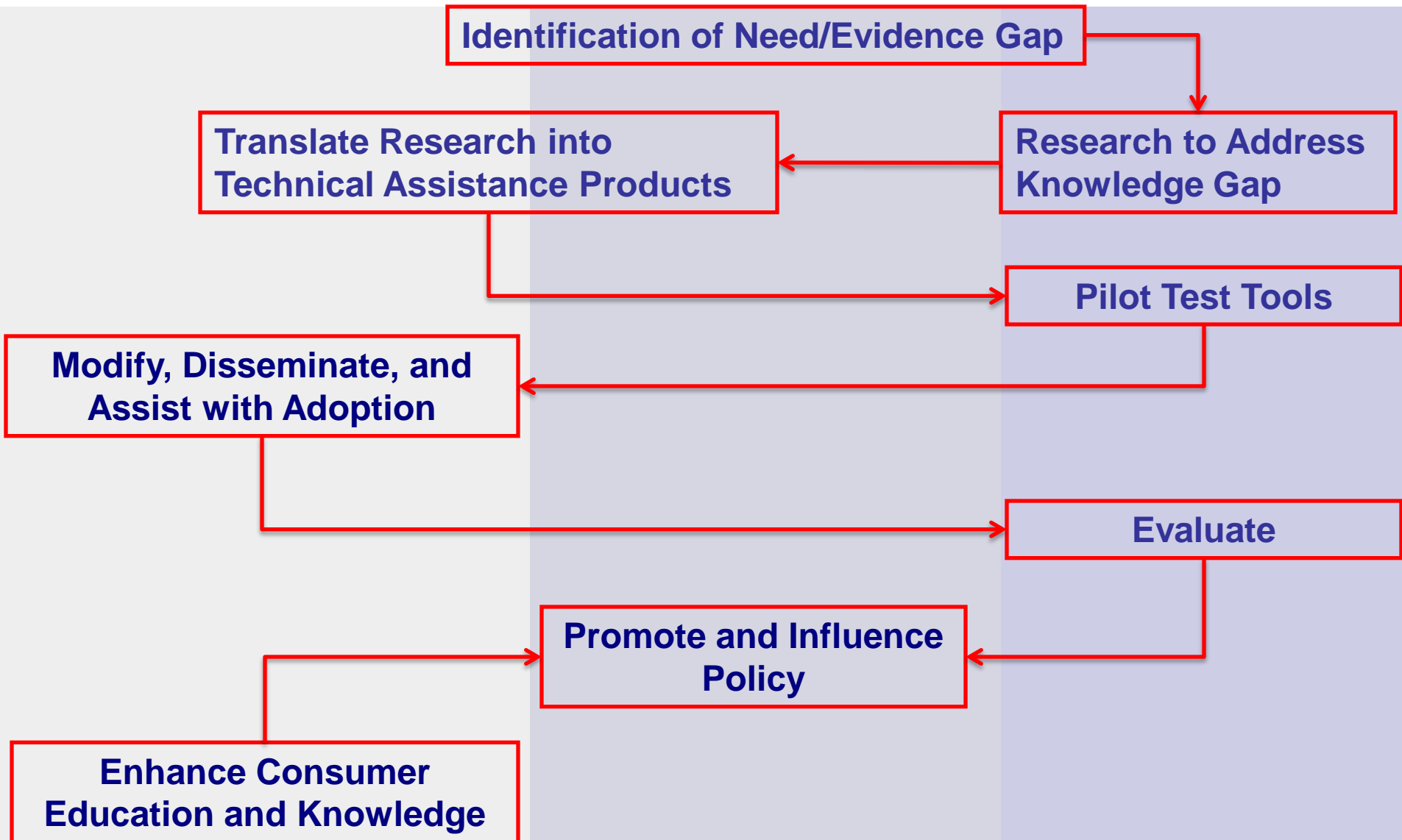
Vision:

- 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





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)

ORIGINAL INVESTIGATION

Cost Savings Associated With US Hospital Palliative Care Consultation Programs

R. Sean Morrison, MD; Joan D. Penrod, PhD; J. Brian Cassel, PhD; Melissa Caust-Ellenbogen, MS; Ann Litke, MFA; Lynn Spragens, MBA; Diane E. Meier, MD; for the Palliative Care Leadership Centers' Outcomes Group

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 \$4908 and \$279

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.

JOURNAL OF PALLIATIVE MEDICINE
Volume 13, Number 8, 2010
© Mary Ann Liebert, Inc.
DOI: 10.1089/jpm.2010.0038

Hospital-Based Palliative Care Consultation: Effects on Hospital Cost

Joan D. Penrod, Ph.D.,¹ Partha Deb, Ph.D.,² Cornelia Dellenbaugh, M.P.H.,¹
James F. Burgess, Jr., Ph.D.,³ Carolyn W. Zhu, Ph.D.,¹ Cindy L. Christiansen, Ph.D.,⁴
Carol A. Luhrs, M.D.,⁵ Theresa Cortez, M.S.N., N.P., ACHPN,⁶ Elyse Livote, M.S.,⁷
Veleka Allen, M.S.,¹ and R. Sean Morrison, M.D.⁷

Abstract

Context: Palliative care consultation teams in hospitals are becoming increasingly more common. Palliative care improves the quality of hospital care for patients with advanced disease. Less is known about its effects 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 hospital care. October 1, 2004 and September 30, 2006.

Main outcome measures: We studied the costs and intensive care unit (ICU) use of palliative versus 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 outcome.

Results: The average daily total direct hospital costs were \$464 a day lower for the 606 patients receiving palliative care compared to the 2715 receiving usual care ($p < 0.001$). Palliative care patients were 43.7 percentage points less likely to be admitted to ICU during the hospitalization than usual care patients ($p < 0.001$).

Conclusions: Palliative care for patients hospitalized with advanced disease results in lower costs of care and less utilization of intensive care compared to similar patients receiving usual care. Selection on unobserved characteristics plays an important role in the determination of costs of care.

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 symptom distress,^{1,2} poor communication between patients and physicians,³ treatment decisions in conflict with prior stated preferences of patients and families,⁴ emotional and financial burdens for families,⁵ and sites of death discordant with patients' expressed preferences.⁶ Moreover, such care is costly. Elderly veterans incur an average of \$43,795 in Medi-

care and Department of Veterans Affairs (VA) costs combined in the last year of life.⁸ Most of the spending is for hospital care, with a substantial portion going for care in the intensive care unit (ICU).^{7,8} Concerns about the quality and costs of care for patients with life-limiting diseases are particularly significant for the VA health care system, the largest, integrated health care system in the nation. VA will be caring for an increasing proportion of veterans with life-limiting conditions as Vietnam-era veterans age and younger veterans with combat-related disabilities return from Iraq and Afghanistan.

DOI: 10.1089/jpm.2010.0038
HEALTH CARE RES
NO. 3 (2010) 454-463
©2011 Project HOPE—
The Hospice and Palliative Health
Foundation, Inc.

THE CARE SPAN

By R. Sean Morrison, Jessica Dietch, Susan Ludwig, Timothy Quill, Joseph Sacco, John Tangeman, and Diane E. Meier

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.

R. Sean Morrison (sean.morrison@sean.edu) is a professor in the Department of Geriatrics and Palliative Medicine at Mount Sinai School of Medicine in New York City.

Jessica Dietch is the director of research at the Center to Advance Palliative Care at Mount Sinai School of Medicine.

Susan Ludwig is a health project coordinator, Palliative Care Team, at the School of Medicine and Dentistry, University of Rochester, in Rochester, New York.

Timothy Quill is a professor of medicine, psychiatry, and medical humanities at the University of Rochester.

Joseph Sacco is the director of the Palliative Medicine Consultation Service at the Bronx Lebanon Hospital Center, in the Bronx, New York.

John Tangeman is the associate medical director at the Center for Hospice and Palliative Care, in Chesham, New York.

Diane E. Meier is a professor in the Department of Geriatrics and Palliative Medicine at Mount Sinai School of Medicine.

Medicaid spending, excluding the \$87 billion in relief provided through the American Recovery and Reinvestment Act of 2009, increased by 9 percent (\$18 billion) in 2009—the highest rate of growth in more than a decade.⁹ This increase occurred even though nearly every state adopted at least one new Medicaid policy that resulted in reductions to patient benefits and payments to healthcare providers.¹⁰ It is estimated that annual Medicaid spending will increase from \$339 billion in 2010 to \$458 billion in 2020.¹¹

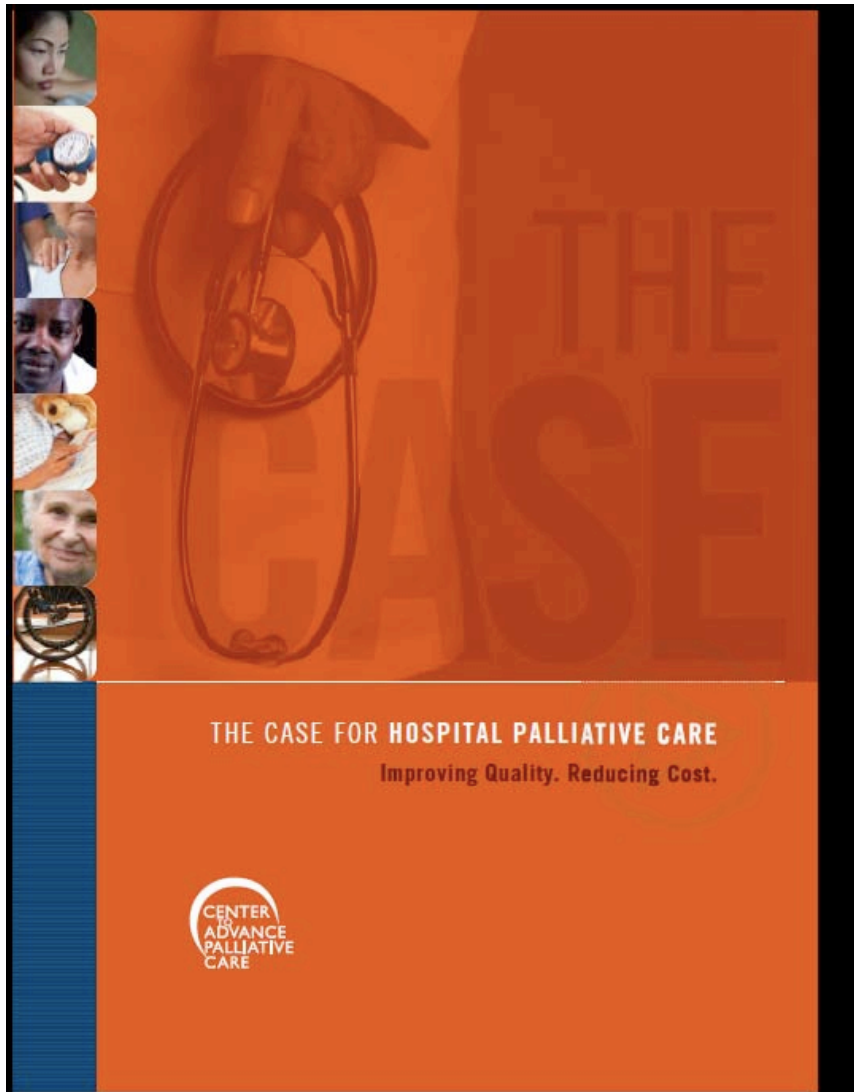
The national economy is expected to improve—although slowly—but state revenues are not. This means that enrollment in Medicaid, which swelled during the economic downturn, is likely to remain high. States will continue to be

challenged to maintain existing eligibility requirements, benefit levels, and provider payments.¹²

The escalating costs of the Medicaid system endanger not only the health of its enrollees, but also the health of the country's economy. Indeed, in its report, *The Budget and Economic Outlook: Fiscal Years 2010 to 2020*, the Congressional Budget Office cites federal health care spending—which includes Medicare as well as Medicaid—as the “single greatest threat” to the stability of the US budget.¹³

Past and present efforts to reduce Medicaid spending have focused on reducing provider reimbursement, tightening and reducing eligibility for programs, deploying Medicaid managed care programs with capitation, and devising formulary restrictions.¹⁴ Although Medicaid

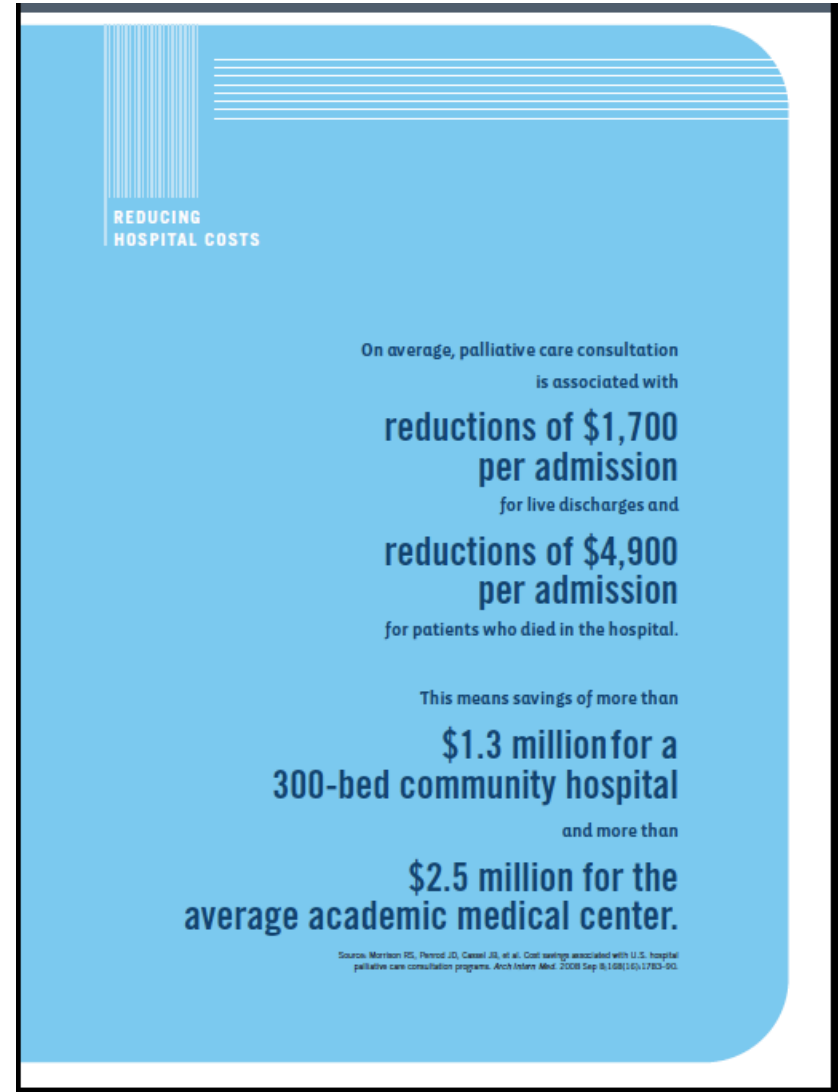
The CAPC Products



The cover of the brochure features a vertical strip of six small images on the left: a woman's face, hands holding a pill, a woman's hands, a man's face, a woman holding a bird, and a woman's face. The background is a solid orange color with a faint, large-scale graphic of a stethoscope and the words 'THE CASE' in a serif font. At the bottom, there is a dark blue horizontal band.

THE CASE FOR HOSPITAL PALLIATIVE CARE
Improving Quality. Reducing Cost.

CENTER
TO
ADVANCE
PALLIATIVE
CARE



The content page has a light blue background with a white border. It features a graphic of vertical lines on the left side, resembling a barcode or a stylized 'R'.

REDUCING
HOSPITAL COSTS

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.**

Source: Morrison RS, Perrod JD, Cassel JJ, et al. Cost savings associated with U.S. hospital palliative care consultation programs. Arch Intern Med. 2008 Sep 8;168(16):1793-90.



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

The Research

JOURNAL OF PALLIATIVE MEDICINE
Volume 11, Number 8, 2008
© Mary Ann Liebert, Inc.
DOI: 10.1089/jpm.2008.0053

Variability in Access to Hospital Palliative Care in the United States

Benjamin Goldsmith, B.A.,^{1,2} Jessica Dietrich, M.P.H.,³ Qingling Du, M.S.,¹ and R. Sean Morrison, M.D.¹⁻⁴

Abstract

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

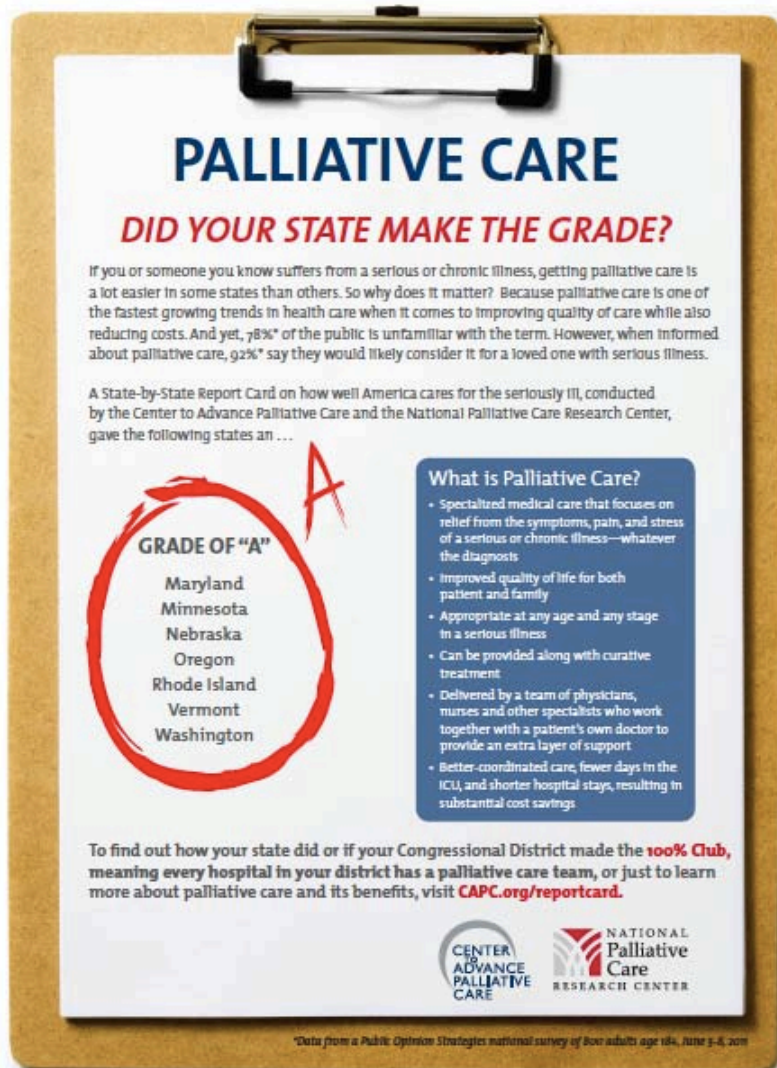
Objective: To examine geographic variation in patient and medical trainee access to hospital palliative care and to examine predictors of these programs.

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% (144/352) of public hospitals, 20.3% (84/413) of for-profit hospitals, and 28.8% (160/554) 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 health care when it comes to improving quality of care while also reducing costs. And yet, 78%* of 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 ...

A



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 800 adults age 18+, June 5-8, 2011






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. Weissman, 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 38 preferred practices associated with quality palliative care. In an effort to provide supportive operational detail about specific features necessary for program sustainability and growth and to help guide hospitals starting new or strengthening existing palliative care programs, the Center to Advance Palliative Care 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 2006.¹ 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 receptive hospital administrators. For almost 10 years, the Center to Advance Palliative Care (CAPC) and its six Palliative Care Leadership Centers^{2M} 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 Center^{2M} faculty have learned what is helpful to, and what hinders, program development.

The National Quality Forum (NQF)'s, *A Framework for Preferred Practices for Palliative and Hospice Care Quality*, developed in 2006, has been a keystone for helping legitimize palliative care practice and provides a clear set of 38 practices necessary for delivery of quality palliative care (Table 1).² 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 Center (PCLC)^{2M} faculty was convened in the winter of 2008 to answer the question, "What operational details are essential, for sustainability/growth, 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 consolidated recommendations within 12 discrete but complementary domains. Within each domain, one or more recommendations have been made as either a "must-have" or a "should-have" program feature. The panel recognized the wide range of hospital size (some program elements will be more difficult to implement for smaller hospitals) and that larger hospitals have a responsibility for a greater scope of services. It is not expected that new programs, or programs from small hospitals, will be able to meet all the must-have recommendations at 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 by hospitals in the planning phase. Users should look upon these recommendations as a work in progress; as the field matures, we anticipate future refinement will be needed.

Center to Advance Palliative Care Palliative Care Clinical Care and Customer Satisfaction Metrics Consensus Recommendations

David E. Weissman, M.D.,¹ R. Sean Morrison, M.D.,² and Diane E. Meier, M.D.²

Abstract

Data collection and analysis are vital for strategic planning, quality improvement, and demonstration of palliative care program impact to hospital administrators, private funders and policymakers. Since 2000, the Center to Advance Palliative Care (CAPC) has provided technical assistance to hospitals, health systems and hospices working to start, sustain, and grow nonhospice palliative care programs. CAPC convened a consensus panel in 2008 to develop recommendations for specific clinical and customer metrics that programs should track. The panel agreed on four key domains of clinical metrics and two domains of customer metrics. Clinical metrics include: daily assessment of physical/psychological/spiritual symptoms by a symptom assessment tool; establishment of patient-centered goals of care; support to patient/family caregivers; and management of transitions across care sites. For customer metrics, consensus was reached on two domains that should be tracked to assess satisfaction: patient/family satisfaction, and referring clinician satisfaction. In an effort to ensure access to reliably high-quality palliative care data throughout the nation, hospital palliative care programs are encouraged to collect and report outcomes for each of the metric domains described here.

Introduction

THE LAST 10 YEARS HAVE SEEN the establishment and revision of clinical practice guidelines and frameworks for preferred palliative and end-of-life practices developed by consensus and best-evidence review processes. These include the National Consensus Project for Quality Palliative Care *Clinical Practice Guidelines*, the National Comprehensive Cancer Network *Advanced Cancer and Palliative Care Treatment Guidelines for Patients*, the National Quality Forum *National Framework and Preferred Practices for Palliative and Hospice Care Quality*, and the Institute for Clinical Systems Improvement *Palliative Care Guidelines*.¹⁻⁴ A core feature of all these documents is an emphasis on measuring and improving the quality of care for seriously ill patients and their families.

As a relatively new specialty, hospice and palliative medicine must be held to the same standards of accountability as others, but we lack high-quality research from which to draw conclusions.⁵⁻¹⁶ There are scant data demonstrating that the presence of specific processes, or measurement of specific outcomes in hospice and palliative medicine reproducibly leads to improved care.⁵ Furthermore, there are a host of

methodological problems in measuring palliative care clinical quality and customer satisfaction.¹⁷⁻²⁰ However, in spite of the existing problems, the need to measure what we do is essential, because patients and families deserve the high standards of care promised by our palliative care programs. In addition, as palliative care programs are required to defend their existence in an era of tightening financial constraints, longitudinal data that can track program impact have become critical to ensuring sustainability.²¹

Fortunately, there has been extensive work on palliative care quality metrics over the past 15 years including individual institution and cooperative research projects in the United States, Canada, Great Britain, and elsewhere, to evaluate various tools and assessment methodologies.²²⁻³² Many validated tools are now available spanning the spectrum of pain and symptom management, care coordination, and patient/family satisfaction.³³⁻³⁹

Since 2000, the Center to Advance Palliative Care (CAPC) and its nine Palliative Care Leadership Centers^{2M} have provided outreach and technical assistance to more than 1300 U.S. hospitals. To ensure program quality and sustainability, CAPC has stressed that programs must measure key

The Product

NATIONAL PALLIATIVE CARE
Registry



[Home](#)

[Register Your Program](#)

[Log In](#)

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?

Register Now

Already started your
registration?

Log In

Not sure if your
program is registered?

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

Patient and Family
Engagement

Population Health

Safety

Care Coordination

Palliative and End-of-
Life Care

Overuse

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>

CERTIFICATION
ADVANCED
PALLIATIVE
CARE

New in 2008
Joint Commission
Certification for
Palliative Care
Programs

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

 **The Joint Commission**
Certification
Health Care Services