



## Palliative Care in Hospitals

A report from the  
*Center to Advance Palliative Care*

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### In 10 minutes...

1. What is palliative care?
2. How does it differ from hospice?
3. Impact of palliative care on quality and costs
4. Policy priorities

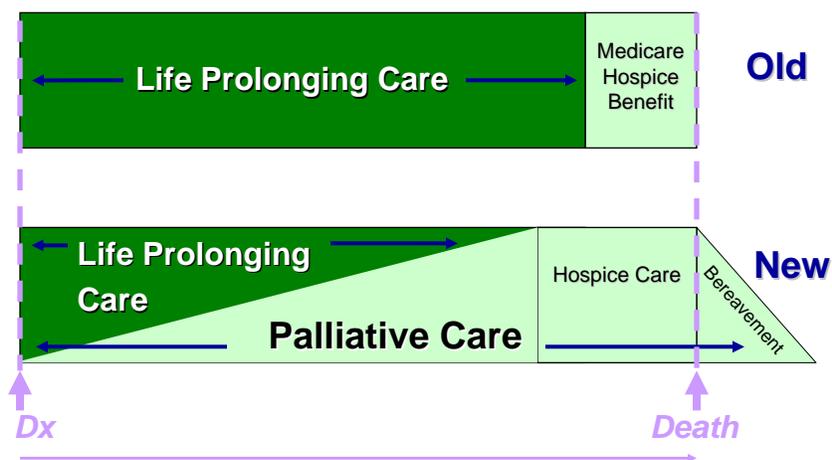
## What is Palliative Care?

- Palliative care is the medical specialty focused on preventing and relieving suffering and improving quality of life for people facing serious illness.
- It is not dependent on prognosis and can be delivered along with curative treatment.

## How Does Palliative Care Differ from Hospice?

- Hospice care provides palliative care for those in the last weeks-months of life.
- Non-hospice palliative care is appropriate at any point in a serious illness. It can be provided at the same time as life-prolonging treatment.

## Conceptual Shift for Palliative Care



## Palliative Care Improves Care in 3 Domains

1. Relieves physical and emotional suffering
2. Improves patient-professional communication and decision-making
3. Coordinates continuity of care across settings

## Palliative care improves quality

Compared to conventional care, palliative care is associated with:

- Reduction in pain and non-pain symptoms
- Improved patient/family satisfaction
- Reduced hospital length of stay and cost

*Jordhay et al Lancet 2000; Higginson et al, JPSM, 2003; Finlay et al, Ann Oncol 2002; Higginson et al, JPSM 2002.*

## Palliative care reduces costs

Cost and ICU Outcomes Associated with Hospital Palliative Care Consultation

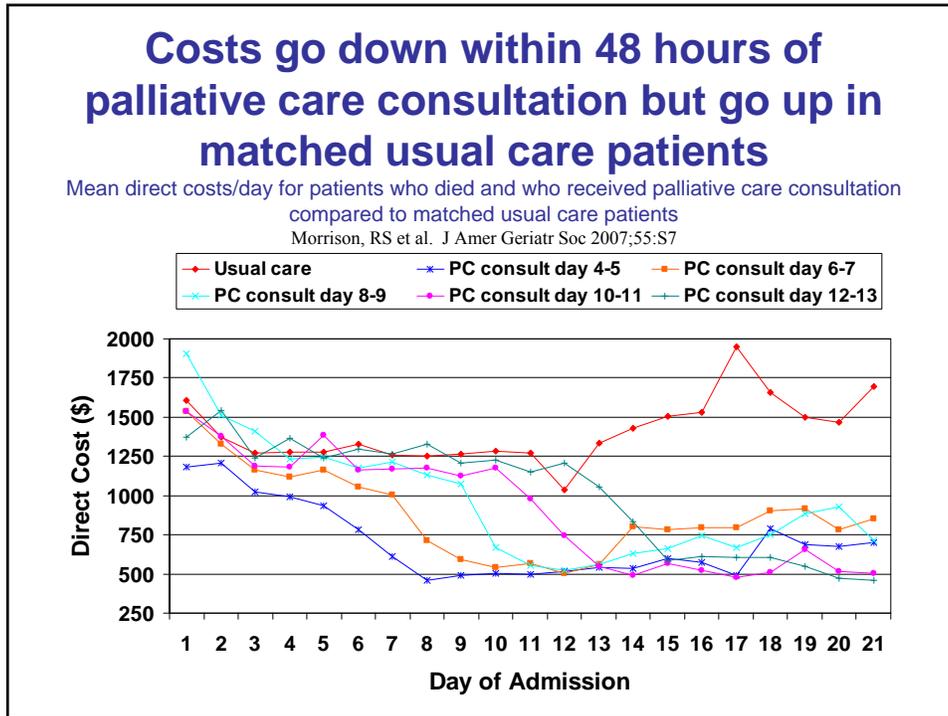
	Live Discharges			Hospital Deaths		
Costs	Usual Care	Palliative Care	Δ	Usual Care	Palliative Care	Δ
Per Day	\$867	\$684	\$183*	\$1,515	\$1,069	\$446*
Per Admission	\$11,498	\$9,992	\$1,506*	\$23,521	\$16,831	\$6,690*
Laboratory	\$1,160	\$833	\$327*	\$2,805	\$1,772	\$1,033*
ICU	\$6,974	\$1,726	\$5,248*	\$15,531	\$7,755	\$7,776***
Pharmacy	\$2,223	\$2,037	\$186	\$6,063	\$3,622	\$2,441**
Imaging	\$851	\$1,060	-\$208***	\$1,656	\$1,475	\$181
Died in ICU	X	X	X	18%	4%	14%*

\*p<.001

\*\*p<.01

\*\*\*p<.05

Morrison, RS et al. J Amer Geriatr Soc 2007;55:S7



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## *Final Days*

### Unlikely Way to Cut Hospital Costs: Comfort the Dying

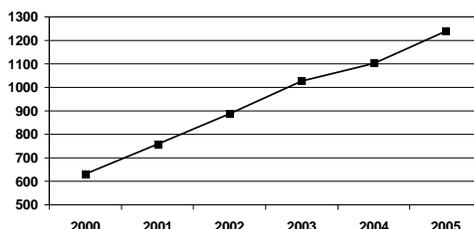
#### Care, Not Cure

Average cost for terminally ill patients in palliative and nonpalliative programs during their final five days at one hospital

	NON-PCU	PCU
Drugs and chemotherapy	\$2,267	\$511
Lab	1,134	56
Diagnostic imaging	615	29
Medical supplies	1,821	731
Room & nursing	4,330	3,708
Other	2,152	278
<b>Total</b>	<b>\$12,319</b>	<b>\$5,313</b>

Note: PCU stands for palliative care unit. Each figure represents average cost of last five days for a cancer patient aged 65-plus, prior to in-hospital death. Figures are for 2001 and 2002.  
Source: Virginia Commonwealth University medical center

## The good news: You can get palliative care in the U.S.



- 30% of U.S. hospitals report a palliative care program
- 70% of hospitals with > 75 beds report a program
- Almost 100% penetration of palliative care into VA hospitals
- [www.getpalliativecare.org](http://www.getpalliativecare.org) to find a program near you

## The bad news: Palliative care research

- Well-documented need for research to increase palliative care evidence base: 4 IOM reports, 2 NIH State of the Science Conferences
- Barriers:
  - **Lack of research funding**
    - <0.1% Of all NIH grants funded 2002-2005 were in palliative care (Gelfman & Morrison, JPM, In press).
    - Federal budget cuts have resulted in a withdrawal rather than an increase in support for palliative care research.
  - Lack of Investigators (junior, mid-career, senior)
  - Lack of Mentors

## Why does research matter?

- Provides critical evidence base to guide quality clinical care for patients and families
- Without research, there will be no palliative care training within the nation's leading medical schools.
  - Power and position within medical schools is based upon research funding and productivity

## How can we ensure that all seriously ill Americans have access to quality palliative care?

Supportive policies:

1. Assure access to care- Build workforce and incent doctors and hospitals to deliver palliative care
2. Assure quality of care- Populate all medical schools with trained faculty, create a workforce pipeline via postgraduate subspecialty training in palliative medicine, set aside funds for research to address pressing problems of human suffering and how best to provide relief.

## Policies to improve access to palliative care

1. **Financial incentives to doctors+nurses** who provide palliative care
2. **Financial incentives to hospitals** that provide palliative care (Norway model)
3. **Hospital accreditation** requirement

## Policies to improve quality of palliative care

1. **Research:** Allocate funding to NIH for research in palliative medicine;
2. ***Palliative Care Training Act*** reintroduction sought to increase numbers of palliative medicine faculty at the nation's 125 medical schools  
<http://www.govtrack.us/congress/bill.xpd?bill=s109-1000>
3. **Post graduate training-** adjust caps so that palliative medicine fellowships are funded.



*"No institution is doing everything right. But we found 10 that are using innovation, hard work and imagination to improve care, reduce errors and save money.*

*Determined people . . . are transforming the way U.S. hospitals care for the most seriously ill patients. The engine of change is palliative medicine.*

*'The field is growing because it pays attention to the details,' says Dr. Philip Santa-Emma ... 'It acknowledges that even if we can't fix the disease, we can still take wonderful care of patients and their families'.*

**Newsweek *Fixing America's Hospital Crisis*  
October 9, 2006**