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IMPROVING HEALTH CARE VALUE THROUGH INCREASED ACCESS TO PALLIATIVE CARE

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Spending for health care services is highly concentrated among a small number of patients. Ten percent of Medicare beneficiaries, for example, account for more than half of total program spending; this group includes those with multiple chronic conditions or functional dependencies,¹ those using hospitals, those with dual eligibility for Medicare and Medicaid (who have a high likelihood of being disabled or residing in a nursing home), and those in their last year of life. In addition to their high spending, studies have shown these patients and their families often face untreated symptoms, unmet psychosocial and practical care needs, high caregiver burden, and low patient and family satisfaction.²

By focusing on patient and family quality of life, palliative care provides an extra layer of support for the seriously ill and offers the potential to moderate spending while improving quality. Interdisciplinary teams of physicians, nurses, social workers, chaplains and other disciplines work with a patient's other physicians to treat symptoms, support decision making and matching of treatments to informed patient and family goals, mobilize practical supports and community resources to ensure a secure living environment, and promote collaborative models of care across multiple care settings.

In the United States palliative care is provided both in and outside of hospice programs. Outside of hospice, the care

is offered independent of prognosis and simultaneously with life prolonging and curative therapies (Figure 1). Hospice care, traditionally focused on patients expected to live less than six months who forego curative care, is thus a subset of palliative care.

CURRENT TRENDS IN PALLIATIVE CARE

Palliative care programs are found increasingly in hospitals, a main site of care for the seriously ill. As of 2009, 63 percent of community hospitals with at least 50 beds and 85 percent of hospitals with more than 300 beds reported having a palliative care program – an increase of 138 percent over the prior decade.³ Data submitted through the National Palliative Care Registry maintained at the Center to Advance Palliative Care (CAPC) suggest that these programs reach 1.5 to 2 percent of discharges, on average, albeit with broad variation across programs. Many palliative care teams are also expanding services to outpatient settings, cancer centers and emergency departments. Additionally, more and more community home care and hospice organizations are providing palliative care for seriously ill patients who are ineligible for hospice.

THE IMPACT ON VALUE

Value in health care can be increased by improving quality or reducing costs, and evidence is building that palliative care is achieving both goals. Studies routinely

demonstrate better quality of life for patients and caregivers, lower symptom burden, and improved family bereavement outcomes in inpatient, outpatient and community settings.^{4,5,6} Other studies demonstrate appreciable cost avoidance as a result of care plans that honor informed patient and family goals, leading to reductions in ICU care, non-beneficial interventions, re-admissions and emergency department visits, and more appropriate and timely referral to community hospice and other programs.^{7,8,9}

Most strikingly, palliative care co-management can extend survival times. In one noted randomized trial, lung cancer patients receiving palliative care not only experienced better quality of life and avoided ICU stays and terminal hospitalizations, but also lived an average of 2.7 months longer than the control group.⁴ Hypotheses advanced to account for increased survival include the avoidance of hospital risks, reduced rates of major depression (an independent predictor of mortality), prevention of severe disabling pain and other symptoms, and better support for family caregivers at home.

BUILDING ON THIS POSITIVE BASE

Palliative care holds the potential to achieve further improvements in health care value as the field expands to reach more patients in need. Currently, approximately 2 percent of hospitalizations end in death and another 4 to 6 percent are for seriously ill patients

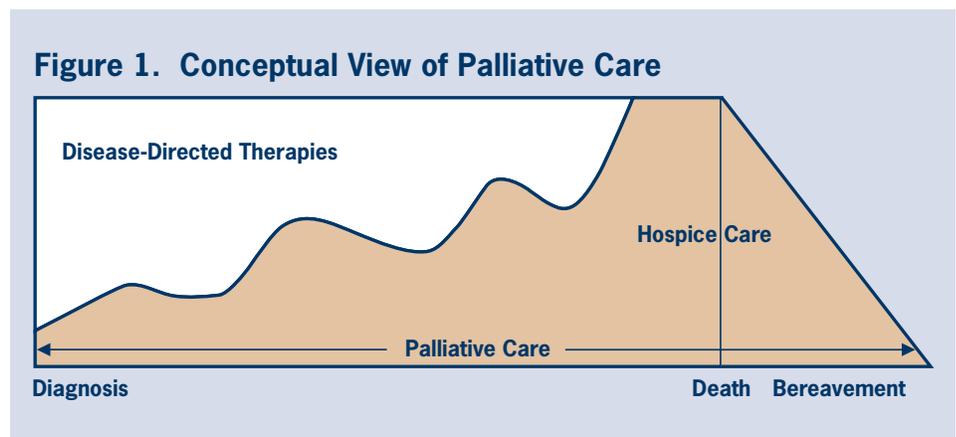
who are discharged alive. Assuming that most of these patients could benefit from palliative care, we should be striving to reach 6 to 8 percent of all discharges, a four-fold increase above current rates. To achieve this level of use, the field must tackle three key challenges.

Variable Access. Data from CAPC show that access to palliative care is highly variable across the country, with smaller, for-profit, safety net and Southern hospitals all less likely to offer this care. Furthermore, access varies even among hospitals with a team in place; existing programs vary in their capacity, and attending physicians' lack of referrals to palliative care can impede access to services.

Standardizing early identification of patients who can benefit from palliative care could help reduce variable access. Recent proposals for universal screening for palliative care needs upon admission to hospital or nursing home and among outpatients living with serious illness¹⁰ and for integration of palliative care into standard oncology care as soon as a patient is diagnosed with metastatic cancer¹¹ would be steps in the right direction. Regulatory and accreditation requirements for palliative care would also help to standardize program availability and quality of care.

Workforce. Workforce challenges include shortages of palliative medicine specialists and other members of the interdisciplinary team as well as a lack of palliative care competency among all medical professionals who care for seriously ill patients. A recent study estimated a shortfall of 2,800 to 7,500 full-time equivalent physicians just to meet the needs of existing hospices and hospital palliative care programs, which translates to 6,000 to 18,000 new specialists depending on the share of practice hours each physician devotes to palliative care.¹² These estimates would be much higher if they included the workforce needed to serve seriously ill patients in community settings outside of the hospital and hospice. Beyond patient care, we also need faculty who can teach palliative medicine and conduct the research needed to improve the field's evidence base.

Addressing these workforce shortfalls will require adequate compensation, loan forgiveness, and career development awards, along with an increase in training opportunities. To date, training in palliative medicine has been largely dependent on private-sector philanthropy due to the cap on Medicare-funded GME slots and their allocation to more traditional specialties. Lifting the cap



to permit new training programs in palliative medicine and redistributing current unused slots to palliative care would help to broaden this funding base. Workforce investments also are needed for specialist-level nursing, social work and chaplaincy. Finally, to address knowledge and skill gaps among the broader medical workforce, accrediting bodies should require demonstrated competencies in pain and symptom management, communication during serious illness, and safe transitions across care settings as a condition of graduation or completion of training.

Research. Despite progress in identifying components of high-quality palliative care programs and creating standards to promote their use, additional research is needed to bolster the evidence base and to test delivery models in a range of patient populations and settings. At a time when our population is aging and people with multiple conditions and functional impairment drive most health spending, less than 0.01 percent of total National Institutes of Health (NIH) extramural funding has gone to palliative care-related research in recent years.¹³ The Senate Appropriations Committee expressed support for emphasis on palliative care research at NIH as recently as 2011, but the outlook for new resources for the field is admittedly dim given current fiscal realities.

CONCLUSION

The evidence of better quality and lower costs associated with palliative care should make improved access to these services a high policy priority. Policy levers include regulatory and accreditation requirements, investment in training and research, and payment that both incents and rewards provision of quality palliative care. Both public and private sector payers already acknowledge the value of these services. This recognition will grow as accountable care organizations and other

delivery systems striving to provide efficient, high-quality care come to appreciate the value-enhancing contribution of palliative care.

- 1 The Lewin Group. "Individuals Living in the Community with Chronic Conditions and Functional Limitations: A Closer Look." Report to the Office of the Assistant Secretary for Planning and Evaluation, DHHS. January 2010.
- 2 Morrison RS, Meier DE. "Palliative Care." *The New England Journal of Medicine*, 350(25):2582-90. 2004.
- 3 Center to Advance Palliative Care. "America's Care of Serious Illness: A State-by-State Report Card on Access to Palliative Care in Our Nation's Hospitals." May 2011.
- 4 Temel JS, Greer JA, Musikansky A, et al. "Early Palliative Care for Patients with Metastatic Non-Small Cell Lung Cancer." *The New England Journal of Medicine*, 363(8):733-42. 2010.
- 5 Wright AA, Keating NL, Balboni TA, et al. "Place of Death: Correlations with Quality of Life of Patients with Cancer and Predictors of Bereaved Caregivers' Mental Health." *Journal of Clinical Oncology*, 28(29):4457-64. 2010.
- 6 Wright AA, Zhang B, Ray A, et al. "Associations between End-of-Life Discussions, Patient Mental Health, Medical Care Near Death, and Caregiver Bereavement Adjustment." *Journal of the American Medical Association*, 300(14):1665-73. 2008.
- 7 Zhang B, Wright AA, Huskamp HA, et al. "Health Care Costs in the Last Week of Life, Associations with End-of-Life Conversations." *Archives of Internal Medicine*, 169(5):480-8. 2009.
- 8 Morrison RS, Dietrich J, Ladwig S, et al. "Palliative Care Consultation Teams Cut Hospital Costs for Medicaid Beneficiaries." *Health Affairs*, 30(3):454-63. 2011.
- 9 Morrison RS, Penrod JD, Cassel B, et al. "Cost Savings Associated with U.S. Hospital Palliative Care Consultation Programs." *Archives of Internal Medicine*, 168(16):1783-90. 2008.
- 10 Weissman DE, Meier DE. "Identifying Patients in Need of a Palliative Care Assessment in the Hospital Setting: A Consensus Report from the Center to Advance Palliative Care." *Journal of Palliative Medicine*, 14:17-23. 2011.
- 11 Smith TJ, Temin S, Alesi ER, et al. "American Society of Clinical Oncology Provisional Clinical Opinion: The Integration of Palliative Care into Standard Oncology Care." *Journal of Clinical Oncology*, 30:1-9. 2012.
- 12 Lupu D. "Estimate of Current Hospice and Palliative Medicine Physician Workforce Shortage." *Journal of Pain and Symptom Management*, 40(6):899-911. 2010.
- 13 Gelfman LP, Morrison RS. "Research Funding for Palliative Medicine." *Journal of Palliative Medicine*, 11(1):36-43. 2008.