

# Innovations Review From Sg2

Leading Innovations in Hospital Operations

Revised June 2009

## Palliative Care Programs

Do the Benefits of Palliative Care Programs Justify the Additional Investment?

### Innovation Overview

**Palliative care programs** offer comprehensive care focused on the relief of pain and other symptoms related to serious illness. Well-designed and managed programs can provide measurable cost savings. Care can be administered in conjunction with ongoing curative therapies with the goal of reducing suffering, improving quality of life, supporting patients and families, and reducing unnecessary resource utilization. Referrals for palliative services are not restricted to patients considered to be dying. Subsets of palliative care include hospice care (directed at patients with a life expectancy of less than 6 months) and end-of-life care (for patients in the last days, weeks or months of life).

### Key Facts:

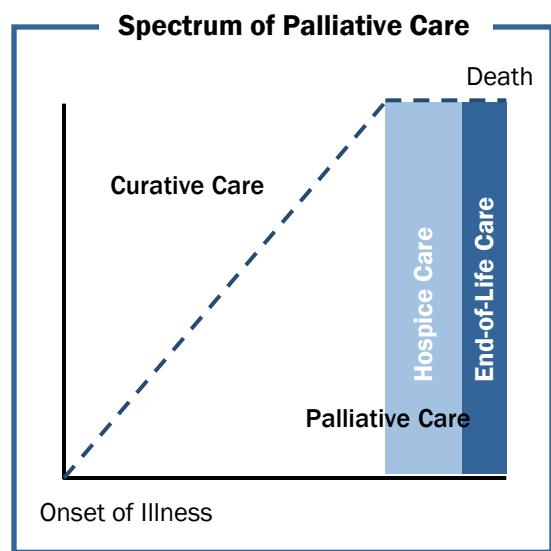
- Hospital-based palliative care programs do not generate significant revenue, rather they provide cost savings by improving the efficiency of care delivery and reducing the resource use during a given hospital stay.
- Approximately 50% of Americans die in hospitals and nearly all Medicare patients who die spend at least some time in a hospital in the year prior to their death.
- Studies have shown that costs for the final days of care for patients who die in the hospital are quite high. Utilization of palliative care services has been shown to reduce costs by up to 80%.

### Key Insights

Palliative care services, which are focused on increasing patient comfort and reducing unnecessary resource use, can decrease variable and/or direct costs. Depending on a facility's budgeting system, savings will be measured and benefits distributed differently.

### Strategic Considerations:

- Potential savings can be estimated by identifying the standard resource use (eg, cost per case, ALOS, ICU stays, readmissions) for the target population and estimating the impact of potential reductions.
- Cost savings estimates should include:
  - Review of historical spending
  - Calculation of minimum savings required to cover program expenses
  - Operational and nonfinancial benefits, including improvements in patient satisfaction and clinical outcomes



ALOS = average length of stay; ICU = intensive care unit.

Sources: American Academy of Hospice and Palliative Medicine. [www.aahpm.org](http://www.aahpm.org). Accessed June 2009; Brown Facts on Dying: USA and State Statistics. [www.chcr.brown.edu/dying/usastatistics.htm](http://www.chcr.brown.edu/dying/usastatistics.htm). Accessed April 1, 2009; Palliative Care in California. [www.chcf.org](http://www.chcf.org). Prepared for California HealthCare Foundation, May/November 2007.

## Building a Successful Program

### Palliative Care Programs—Key Characteristics

<b>Program Elements</b>	<p>In order to realize optimal cost savings, programs must be carefully structured, staffed and scoped to meet the needs of individual organizations and patient populations.</p> <p><b>Structure</b></p> <ul style="list-style-type: none"> <li>▪ The most common program structures include:           <ul style="list-style-type: none"> <li>▪ <b>Consultation Services:</b> A dedicated staff provide on-demand services for maximum flexibility at minimal expense. Low clinical input on the part of the palliative care team may result in lower cost savings. Education and a focus on data tracking are essential.</li> <li>▪ <b>Inpatient (IP) Units:</b> Dedicated space and staff allow for maximum clinical control and most efficient use of resources. Expenses may be higher and operational issues may arise from the need to transfer patients to the unit. Units can be combined with consultation services.</li> <li>▪ <b>Swing-Bed/Flexible-Use Units:</b> Select patient rooms are redesigned to be more home-like. Rooms can be distributed throughout the facility to minimize patient transport and allow for flexing to nonpalliative patients when demand is low. Consultation services are often provided.</li> </ul> </li> </ul> <p><b>Staffing</b></p> <ul style="list-style-type: none"> <li>▪ No single staff member has the expertise to address all of the needs of a palliative care patient, making a multidisciplinary team essential.</li> <li>▪ Palliative care services are best provided by a team including a physician, nurse, nurse practitioner and social worker. Other team members may include pastoral care staff, therapists, pharmacists, mental health professionals, rehabilitation staff and volunteers.</li> <li>▪ Regardless of structure, staffing costs are the largest portion of a palliative care program budget and are scalable based on demand for services and success of cost-savings efforts.</li> </ul> <p><b>Scope</b></p> <ul style="list-style-type: none"> <li>▪ Programs must be designed so that it is clear which patients are eligible for palliative care. Eligibility thresholds can range from only patients with life-threatening diagnoses to all patients.</li> <li>▪ Leading organizations view all patients as potential palliative patients and integrate palliative evaluations into standard care for all patients.</li> <li>▪ Consideration must be given to who will be allowed to request a consult (by standard protocol for all patients or certain units, by physician order only, any staff member, or families and patients).</li> </ul>
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### Case Study

Hospital	Program Statistics	Facts
<b>St Luke's Health System Boise, ID (2 hospitals, 1 with 350 beds and 1 with 100 beds)</b>	<ul style="list-style-type: none"> <li>▪ Consultation services model serving 450 adult beds</li> <li>▪ Program launched in early 2008 and expanded after several months</li> <li>▪ 2 dedicated FTEs (MD and RN)</li> </ul>	<ul style="list-style-type: none"> <li>▪ Program launched in ICU/CCU and expanded to all areas (except ED).</li> <li>▪ The case for services was made up front to administrators and included clinical outcomes, cost benefits and patient satisfaction.</li> <li>▪ Staff education was critical to program success.           <ul style="list-style-type: none"> <li>▪ Monthly lunch lectures are offered internally, with 20 to 30 staff members attending.</li> <li>▪ Monthly case presentations were developed with other palliative care programs in the community (including the competitor hospital).</li> </ul> </li> <li>▪ In the first year, 185 patients were seen. The initial goal was to see 100 patients per year.</li> </ul>

CCU = critical care unit; ED = emergency department.

## Innovation Performance Summary

### Clinical

- SUPPORT study found that 40% of patients experienced moderate to severe pain in the last 3 days of life.
- Monitoring outcomes and quality metrics for patients receiving palliative services can assist clinicians in managing care.
- Many state laws include mandatory training in palliative care for clinicians.

### Financial

- Palliative care can generate cost savings through reductions in resource use.
  - A study found total daily costs per patient were 57% lower in an IP palliative care unit compared to an ICU (mean: \$1,095 vs \$2,538).
- Another study found proactive palliative care consultation to significantly reduce MICU LOS in a high-risk population without significant difference in mortality rates or discharge disposition.
- Cost avoidance from palliative care programs can have a large impact on variable and direct costs, which typically account for 40% to 60% of total costs.

### Measurement

- Tracking key metrics is crucial to monitor progress and effectiveness and to provide justification for palliative care services.
- Key metrics include:
  - Target patient population statistics (eg, volume, mortality, acuity)
  - Encounter-level data (eg, top DRGs, LOS, referral source, physician, payer)
  - Financial data (eg, total cost, estimated avoidable direct or variable costs, reimbursement)
  - Satisfaction (patient, family, staff, physician)
  - Program expenses (eg, capital/construction, staffing, educational)

### Satisfaction

- Palliative services provide clinical support to relieve pain and other undesirable symptoms.
  - Adverse events are reduced with better monitoring and patient education.
- Physician and staff satisfaction can be improved by allowing providers to offer high-quality, patient-centric care and eliminating frustration from futile, disorganized care.

## Implementation Considerations

- Careful data collection and presentation of findings in a meaningful way to key administrators will include a review of historical data, estimated patient populations, potential cost savings, and program staffing and expenses, as well as the impacts on clinical outcomes, length of stay and patient satisfaction.
- Determine the best program structure and scope of services based on your estimated target patient population and organizational needs. Discussion of program structure should include availability of space and capital resources. Staffing needs will be based on the selected program structure and size.
- Initial program planning should include estimates of referrals and growth. Programs that are unable to meet unanticipated demand often struggle to provide meaningful services and realize the full impact of cost savings on an ongoing basis.

Acknowledgments: Sg2 would like to thank Amy Balstad, RN from St Luke's Health System, Boise, ID for her contributions to this report. LOS = length of stay; MICU = medical intensive care unit; SUPPORT = Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments; DRG = diagnosis-related group.

Sources: Center to Advance Palliative Care, 2007; Gilmer T et al. *Health Aff (Millwood)* 2005;24:961–971; Smith TJ et al. *J Palliat Med* 2003;6:699–705; Teno JM et al. *JAMA* 2004;291:88–93; Norton et al. *Crit Care Med* 2007;35:1530–1535; Sg2 Interviews and Analyses, 2008.