Early palliative care cuts costs for critically ill patients

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Palliative care delivered early during hospitalization can help cut costs for critically ill patients, finds a new study in Health Services Research.

"Palliative care programs are increasingly prevalent in U.S. hospitals but the financial incentives for hospitals to deploy them are not well-understood," explains lead author Ian McCarthy, Ph.D., an assistant professor of economics at Emory. Today, 88 percent of large hospitals have palliative care teams and, said McCarthy, palliative care programs have proven "highly effective at addressing a wide range of needs felt by…patients and their families."

Palliative care aims to relieve suffering, be it physical, emotional, social

or spiritual. Unlike hospice, palliative care is not limited to the last six months of life. Nor must palliative care patients be considered terminally ill: they often continue to receive disease-modifying treatments along with palliative care services.

Palliative care is a "fairly new medical specialty that has proven to substantially improve patient outcomes when it's delivered alongside routine treatments," says Sean Morrison, M.D., director of the National Palliative Care Research Center and a professor at Mount Sinai's School of Medicine. With palliative care, said Morrison, "symptoms are better managed, families are better cared for, and patients have better quality of life" with reduced pain and suffering.

The new study had two objectives: (1) to quantify potential savings from in-hospital palliative care teams; and (2) to provide guidance to hospital systems on structuring appropriate care teams and the best ways to use palliative care teams for maximal savings.

The researchers analyzed data gathered between January 2009-to-June 2012 at five hospitals within one Dallas-Fort Worth area hospital system. The sample comprised data from 38,475 inpatient stays for people 18 or older hospitalized for 7 to 30 days; and noted whether patients did or did not receive a palliative care consult.

The results, the authors wrote, revealed that "among patients who died in the hospital, there was a significant cost savings from palliative care of $3,426 per inpatient stay." Contrary to previous research, however, they found no cost savings difference for patients discharged alive. This finding, however, can be explained by difference in timing of palliative care, the patient's diagnosis and make-up of the palliative care team, noted the researchers.

They found that savings associated with palliative care were highest for

patients who had a consult with a palliative care team within the first 10 days of their hospital stay and for patients diagnosed with cancer. Savings also reached their highest levels when a palliative care team included more involvement of physicians and registered nurses.

The findings showed potential savings for palliative care teams even in facilities with high hospice utilization. Hospitals can achieve the highest quality of care and greatest savings by implementing both hospice and palliative care when appropriate.

Morrison called the work "a well designed study with robust findings." Society today is seeking improved health care quality and costs savings, he said, and palliative care has demonstrated that it can contribute on both fronts. He called for requirements to be put in place for hospitals to routinely use palliative care, and to make the regular use of palliative care a condition for participation in Medicare.

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