FINANCIAL ¢HALLENGE$

For Hospital-Based Palliative Care Programs

by J. Brian Cassel, PhD

The number of hospital-based palliative care programs has grown rapidly in the U.S. Today, more than half of hospitals with 300 or more beds offer palliative care.[1] Palliative care programs typically consist of an interdisciplinary team comprised of a physician (not necessarily full-time), advanced practice nurse, registered nurses, and other staff as needed, including social workers, chaplains, physical therapists, and occupational therapists. While the cost of such programs can be in the hundreds of thousands of dollars, few service lines bring as much promise to the table as palliative care. Published and unpublished studies consistently demonstrate that the cost savings of palliative care programs equal or exceed the financial investment. Still, for many hospitals, financial concerns about how to pay for these services continue to be a barrier to establishing a palliative care program.

Controlling Healthcare Costs

Palliative care programs have been shown to improve quality of care (e.g., better symptom management)[2-5] and patient and family satisfaction.[6] These programs can also help control costs.[7-10] Palliative care can reduce healthcare costs, for example, by managing patients into lower-intensity and less-expensive beds and reducing expensive ancillary tests.[11] In 2001, Northwestern University Medical Center's palliative care unit reported a 40 percent cost savings—from $1,985 per day (on their oncology unit) to $1,191 per day (on their palliative care unit).[12]

More recently, Virginia Commonwealth University (VCU) Medical Center experienced a 60 percent cost reduction attributed directly to its palliative care program.[8] In a follow-up study, VCU Medical Center demonstrated that the last five days of inpatient hospital care for cancer patients receiving palliative care was just 43 percent of the cost compared to cancer patients who did not receive palliative care.[9] VCU Medical Center evaluated within-patient differences in the cost per day before and after palliative care consultation for 273 patients who had at least 3 days prior and 3 days post-palliative care consultation and were age 65 or older (see Figure 1). While the room and nursing care were nearly identical for the two patient populations, palliative care patients spent most or all of their last few days in medical/surgical beds—not intensive care unit (ICU) beds. VCU Medical Center also attributed the cost savings to:

- A 77 percent reduction in drug costs
- A 95 percent reduction in lab and imaging costs
- A 60 percent reduction in hospital supplies.

Following the model used at VCU Medical Center, five other leading palliative centers around the country conducted similar internal analyses of the cost control generated by their programs. The number of palliative cases per year ranged from 120 at a small community hospital to more than 1,700 in a three-hospital faith-based community system. Typical length of stay (LOS) following the palliative care consultation was three to six days.

Each center compared direct (or variable) costs per day before and after the palliative care team intervened. In percentage terms the cost control ranged from 13 percent to 60 percent, with 40 percent being the most common outcome. (In other words, if a typical inpatient hospitalization had direct costs of $1,000 per day prior to the palliative care consult; direct costs were reduced to $600 per day after the consult.) Multiplied by patient days and caseload volume, cost savings ranged from $287,000 per year to over $1.5 million.

As you can see, setting aside the value of improved quality, safety, and patient and family satisfaction, these cost savings are more than sufficient to justify investing in a palliative care program.

The Effect on the Revenue Stream

While palliative care programs can reduce healthcare costs, they do not necessarily reduce a cancer center's revenue stream. Reimbursement for complex cases with extended

Five Common Misconceptions about Palliative Care

1. Our hospital budget is tight right now, and we can't afford another new program.
2. A small palliative care team with part-time staff cannot possibly pay for itself.
3. Palliative care programs are financially feasible for large academic medical centers, but not for smaller community cancer centers.
4. If a palliative care program reduces healthcare costs, won't it also reduce the hospital's revenue stream?
5. Our hospital and cancer center are profitable, so adding a palliative care program using the "financial" or "cost-avoidance" argument may not carry much weight with our administration.

LOS often does not even cover the costs incurred by the hospital.

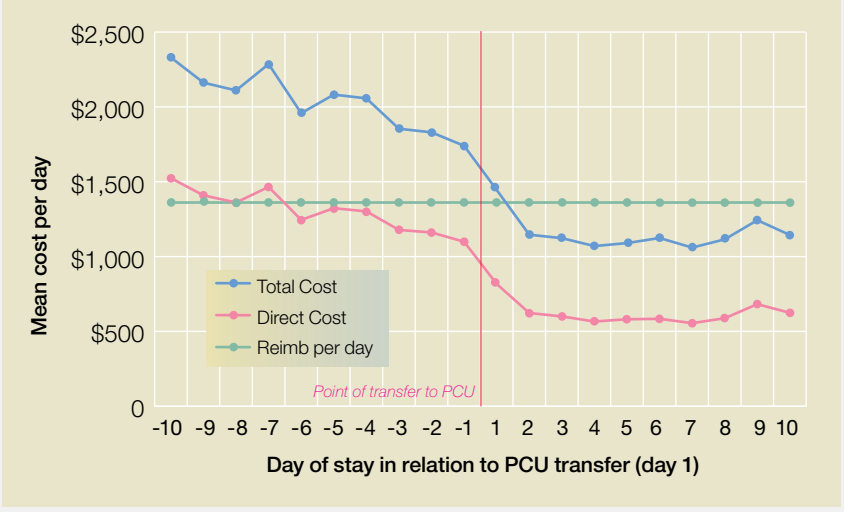
Drill down in your own data to look specifically at your managed care, government-payer (Medicare and Medicaid), and uninsured adult patients who died in your hospital over the past three years. Compute their profit or loss (total reimbursement minus total cost) and disaggregate your data into LOS by weeks (e.g., < 1 week, 1-2 weeks, etc.). Most hospitals will find many decedents for whom the LOS and complexity of care generated costs that exceeded revenue. VCU Medical Center, for example, found that over a four-year period, the losses generated by those patients exceeded the modest profits generated by shorter LOS decedents, by more than three times (even though they occurred in roughly equal numbers). Looking at those patients' prior admissions in the three to six months before death will probably lead to similar results.

Here's another way to look at the situation.

Most palliative care teams function as specialty consultative services, assisting in symptom management, goal clarification, care coordination, and end-of-life care for the entire family. Palliative care teams typically enter the picture several days or weeks into the inpatient stay. A recent benchmarking study in academic medical centers, for example, found the average delay to palliative care consultation to be 8.5 days.[2] In this scenario, the diagnoses and procedures that define the DRG or other basis of reimbursement are already set, and the palliative care team is making modest but significant changes to care that result in better quality, more appropriate care, and controlled cost for the remaining three to six days of the hospital admission. Bottom line: reimbursement is generally not affected, certainly not for payers, such as Medicare, that employ a fixed payment system regardless of the LOS or cost of the stay. Analysts at the University of California at San Francisco have even demonstrated that palliative care consultation does not negatively affect outlier payments, relative to costs.

Figure 1: Reimbursement and Cost Analysis, Per Day, Prior to and after Transfer to Palliative Care Unit+

Cost and reimbursement per day, prior to and after transfer to PCU, for patients aged 65+, all insurance status and payers.



VCU Health System Decision Support data January 2002 – March 2006. Represents 273 patients with at least 3 days stay prior to PC transfer, and at least one day on PCU. First two days of admission deleted from this analysis for all patients. Minimum n for data shown: 89 for pre-transfer days (on day -10) and 35 for post-transfer days (on day 10). Reimbursement per day calculated for cases discharged in FY2002–FY2005 (reimbursement not available for all of FY06).

+For patients aged 65+ across all payers. Source: Virginia Commonwealth University, Massey Cancer Center.

Improving Care

Palliative care programs bring important quality, ethical, and safety benefits for patients and staff. Palliative care and hospice often provide a more appropriate intensity and goal of care for gravely ill patients suffering from chronic diseases, such as cancer, who are near the end of life. Only as a side effect are costs controlled. Palliative care *does not* artificially accelerate the dying process or push gravely ill patients toward death. Palliative care *does* ensure appropriate care in accordance with patient and family wishes that can be less costly than standard American hospital care, which tends to include tests, procedures, and other interventions that are not necessarily beneficial for the patient.

Going Forward

A new model of palliative care is taking shape as the healthcare community is coming to understand that physicians outside of the cancer center (i.e., intensive care physicians, admitting physicians, emergency department physicians) can recognize that a patient is appropriate for palliative care.

Our Program At-a-Glance

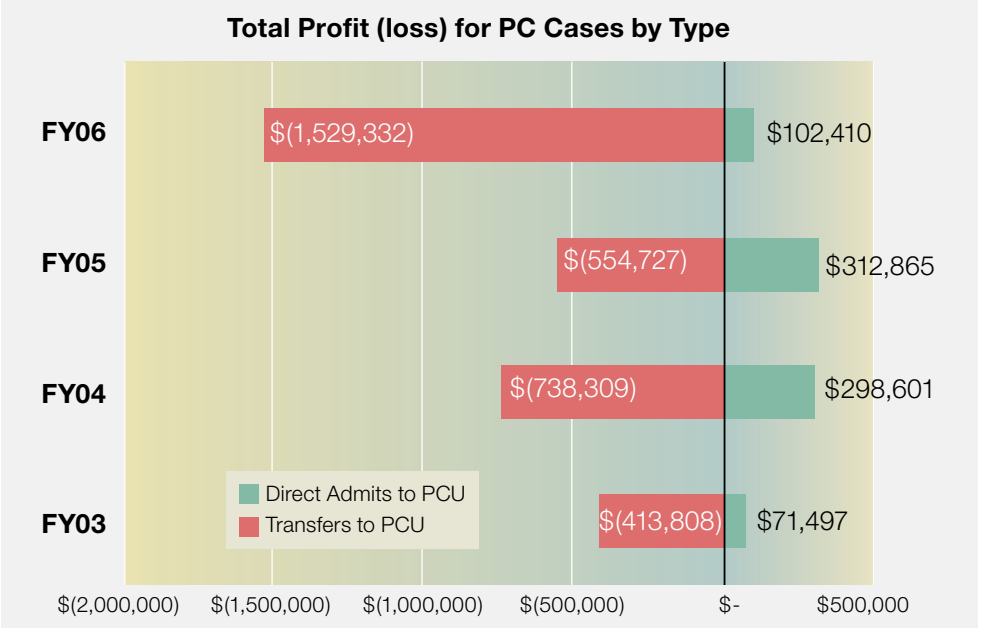
VCU Massey Cancer Center's Thomas Palliative Care Program includes an inpatient consultative service, a dedicated 11-bed unit, and an outpatient clinic. For more information on VCU's palliative care services and training programs, visit *www.massey.vcu.edu* or contact Dr. Brian Cassel by phone: 804.628.1926 or email: jbcassel@vcu.edu.

In fact, at VCU about half of our palliative care patients are admitted directly into the palliative care unit—either through physician referral or through the emergency department. At VCU, we analyzed these patients' total reimbursement compared to their costs (see Figure 2). As you can see, the hospital lost money on transfer cases, while the direct admits were modestly profitable or at break-even. (Palliative care in the last 3 to 6 days of an admission *can* control costs by about 40 percent, but for these patients the financial damage was already done in the previous 8 to 12 days when they received more intensive and costly care.) At VCU, direct admits and transfers have about the same LOS on the palliative care service, that is, about 5 days.

A successful palliative care program requires a commitment from the hospital. Unfortunately some hospital administrators are like those hypertension patients who stop taking their medication when they feel better. In other words, hospitals may cut back on case management and care coordination programs when they no longer have LOS problems. Instead, our recommendation is to combine clinical, patient and staff satisfaction, and financial data and evaluate your palliative care program on an annual basis. This thoughtful process can provide a multifaceted picture of the various positive improvements that a well-run palliative care program can bring to your cancer center and hospital.

J. Brian Cassel, PhD, is senior analyst, VCU Massey Cancer Center, Richmond, Va.

Figure 2: Profit and Loss Comparison of Direct Admits and Transfers to the Palliative Care Unit



Source: Virginia Commonwealth University, Massey Cancer Center.

References

[1]Morrison RS, Maroney-Galin C, Kralovec PD, Meier DE. The growth of palliative care programs in United States hospitals. *J Palliat Med*. 2005; 8(6):1127-1134.
[2]Twaddle ML, Maxwell T, Cassel JB, Liao S, et al. Palliative care benchmarks from academic medical centers. *J Palliat Med.* (In press). 2007;10(1):86-98.
[3]Khatcheressian J, Cassel JB, Lyckholm L, Coyne P, et al. Advancing palliative and supportive care: Recognizing the needs for symptom control, and designing do-able methods to meet them. *Oncology* (Williston Park). 2005;19(10):1365-76.
[4]Higginson IJ, Finlay IG, Goodwin DM, Cook AM, et al. Do hospital-based palliative teams improve care for patients or families at the end of life? *J Pain Symptom Manage.* 2002; 23:96-106.
[5]Higginson IJ, Finlay IG, Goodwin DM, Hood K, et al. Is there evidence that palliative care teams alter end-of-life experiences of patients and their caregivers? *J Pain Symptom Manage.* 2003;25:150-168.
[6]Ringdal GI, Jordhoy MS, Kaasa S. Family satisfaction with end-of-life care for cancer patients in a cluster randomized trial. *J Pain Symptom Manage.* 2002;24(1):53-63.
[7]Brumley RD, Enguidanos C, Cherin DA. Effectiveness of a home-based palliative care program for end-of-life. *J Palliat Med*. 2003;6(5):715-724.
[8]Smith TJ, Coyne PJ, Cassel JB, Penberthy LT, et al. A Hopson & MA Hager. A high volume specialist palliative care unit and team may reduce in-hospital end of life care cost. *J Palliat Med.* 2003;6:699-705.
[9]Naik G. Unlikely way to cut hospital costs: Comfort the dying. *Wall Street Journal*. March 10, 2004, pg. 1.
[10]White KR, Stover KG, Cassel JB, Smith TJ. Nonclinical outcomes of hospital-based palliative care. *J Healthc Manag.* 2006;51(4):260-73.
[11]Roberts KF. Business planning for palliative care. *Oncol Issues*. 2003;18(1):40-41.
[12]Muir JC, Paice JA, McKay A, et al. *Quality Cancer Care at the End of Life: The Role of a Hospital-based Palliative Care Service.* In: Program and Abstract of the ASCO 37th Annual Meeting; May 12-15, 2001, San Francisco, Calif. Abstract No. 1557.