POLICY BRIEF:

Coordinated End-of-Life Care Improves Wellbeing and Produces Cost Savings

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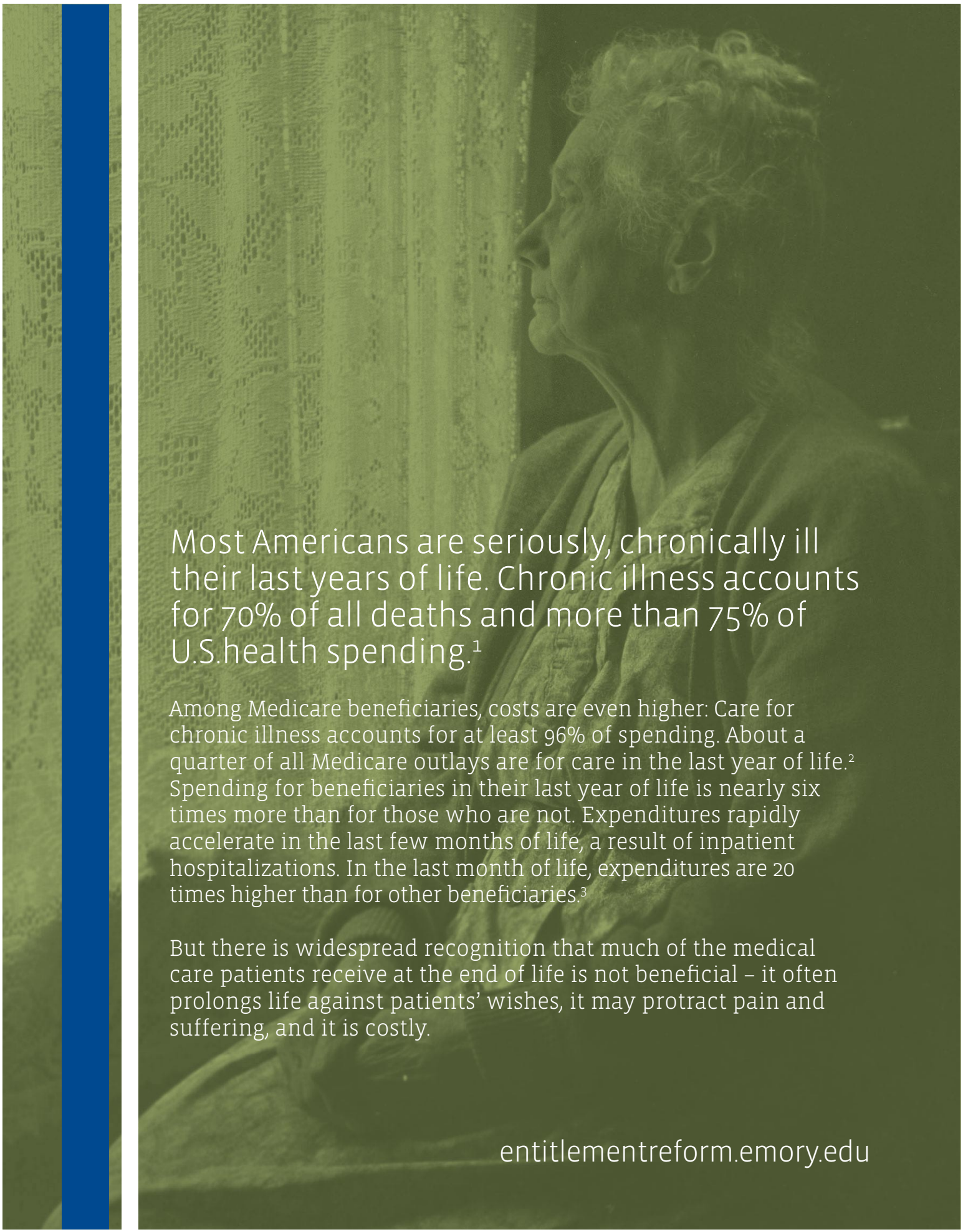

Most Americans are seriously, chronically ill their last years of life. Chronic illness accounts for 70% of all deaths and more than 75% of U.S.health spending.[1]

Among Medicare beneficiaries, costs are even higher: Care for chronic illness accounts for at least 96% of spending. About a quarter of all Medicare outlays are for care in the last year of life.[2] Spending for beneficiaries in their last year of life is nearly six times more than for those who are not. Expenditures rapidly accelerate in the last few months of life, a result of inpatient hospitalizations. In the last month of life, expenditures are 20 times higher than for other beneficiaries.[3]

But there is widespread recognition that much of the medical care patients receive at the end of life is not beneficial – it often prolongs life against patients' wishes, it may protract pain and suffering, and it is costly.

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More than half (55%) of the total amount spent on Medicare beneficiaries during their last two years of life is for acute hospital care, including hospital inpatient facility charges, payments for inpatient physician visits, procedures, and diagnostic tests. The next largest category of spending, for outpatient care, is just 16% of overall spending.[4]

Evidence is mounting that coordinated palliative care – an interdisciplinary specialty that works to improve quality of life for patients with advanced illness – can enhance patient and family wellbeing and save money. Coordinated end-of-life care focuses on **pain and symptom management** (as opposed to recuperative or restorative care); **communication between patients, family, and providers** consistent with care goals; and **safe transitions** between care settings.

Palliative care can be provided at any stage of illness and it should be an integral part of care for medically complex, chronically ill patients.

Evidence of Effectiveness

A systematic review of studies supports the effectiveness of multidisciplinary palliative care teams in different settings – in hospitals, hospices, and at home – and in urban and rural areas.[5] Recent research confirms these findings:

› A study of the palliative care unit at the M.D. Anderson Cancer Center demonstrated that it improved patients' symptoms and relieved both physical and psychological distress. Mean daily charges in the palliative care center were 38% lower than the rest of the hospital.[6]

› Proactive palliative care for patients in a medical intensive care unit of a large academic hospital in New York resulted in significantly shorter lengths of stay in intensive care, potentially saving up to 1,400 bed-days annually.[7]

› The Kaiser Permanente Palliative Care Project uses a multidisciplinary approach to home-based care during the last 12 months of life. Research shows that, compared to usual care patients, enrolled palliative care patients were more satisfied with services and had significantly fewer emergency department visits, hospital days, skilled nursing facility days, and physician visits. Their care cost 45% less overall than usual care, averaging $6,580 less per patient.

› Hospital-based multidisciplinary palliative care teams achieve cost savings both for patients who are discharged alive (either to home, hospice, or other facility) or who die in the hospital compared to patients who receive usual care. In a large retrospective study, those discharged alive had an adjusted net savings of $1,696 in direct costs per admission and $279 per day. Those who died had an adjusted net savings of $4,908 in direct costs per admission and $374 per day.[8]

› A study of more than 600 patients with advanced cancer found that end-of-life conversations with their physicians both improved quality of life in their last week and significantly lowered health care costs, largely because they had limited use of intensive interventions. More interventions and higher spending were not associated with better outcomes. In fact, the reverse was true. Patients who received intensive interventions had worse quality of life in their final week.[9]

Potential Cost Savings

Approximately 1.5% of all hospital discharges (30,181,406/year for all payers) are currently managed by palliative care services, just under 453,000 patients annually. Average cost savings estimated from the literature are, conservatively, $2,659 per patient, for an overall savings of $1.2 billion possible currently.[10]

Building on the research evidence, cost savings from coordinated palliative care could reach more than $37 billion over ten years. **Table 1** *(below)* shows achievable savings associated with a range of hospital discharges (starting at 1.5% of all discharges now and rising to 7.5% of discharges by 2019).

These estimates are conservative, because they consider only direct costs of avoided acute care and not savings resulting from prevented readmissions, other medical care utilization, and improved system capacity. Further, they assume a 5% uptake rate in palliative care services prior to hospital discharge. Potential savings at a target rate of 7.5%, which is achievable, would be 60% greater. Additionally, these estimates are predicated on Medicare patients accounting for just 40% of discharges for targeted patients; savings in Medicare can be presumed to be significantly higher.

TABLE 1: Federal Savings Associated with Palliative Care Models (Dollars in Billions)

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Savings over 10 Years
Savings starting at 1.5% of hospital charges (baseline) and baseline growth/year	$1.2	$1.4	$1.5	$1.6	$1.7	$1.9	$2.0	$2.2	$2.4	$2.5	$18.4
Savings at 5% of hospital discharges		$1.4	$1.8	$2.3	$2.8	$3.7	$4.7	$5.8	$7.1	$8.6	$38.1
Savings at 7.5% of hospital discharges		$1.4	$2.3	$3.3	$4.2	$5.2	$6.6	$8.0	$10.3	$13.0	$54.4
NET SAVINGS (Potential Less Baseline)											
5% penetration savings (low end)		$ -	$0.3	$0.6	$1.1	$1.8	$2.6	$3.6	$4.8	$6.1	$20.9
7.5% penetration savings (high end)		$(0.0)	$0.9	$1.7	$2.5	$3.4	$4.6	$5.8	$7.9	$10.4	$37.2

Policy Recommendations

Currently, palliative care services are available in only a third of all U.S. hospitals. Just half of hospitals with >50 beds offer palliative care services and 80% of hospitals with >300 beds. Programs are variable across the country, with the South lagging in services. For profit, public, and sole community provider hospitals are less likely to offer palliative services than large teaching hospitals.[11]

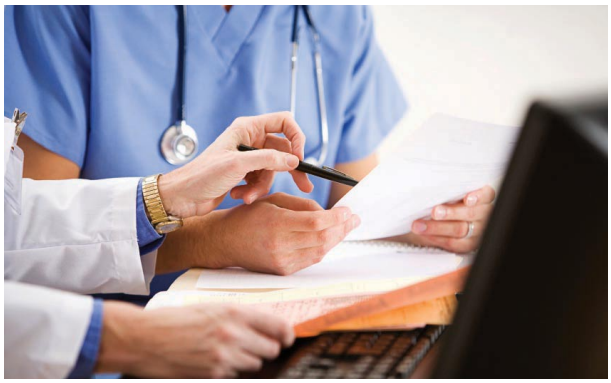
› Set an uptake goal of 7% of annual hospital discharges, targeting patients who are most likely to die in the hospital and patients who are very sick but likely to be discharged alive to home, hospice, or other facility.

› Increase hospital-based palliative care programs from 33% to 75%. Require these programs to meet quality standards as a condition for accreditation.

› Alter financial incentives to reward proactive, coordinated palliative care for patients through bundled payments.

› Build the necessary interdisciplinary workforce through Medicare support of medical education and loan forgiveness programs for primary care, geriatrics, and palliative care.

Evidence shows that more care does not always mean better care, better health outcomes, or better quality of life.



Evidence-based palliative care models are highly effective in improving care quality for seriously ill patients and, at the same time, decreasing the costs of end-of-life care. Most important, palliative care programs offer the support patients and their families need to make decisions consistent with their individual goals. By facilitating clear communication between doctors, patients and their families, providing effective pain and symptom management, and overseeing safe transitions between care settings, palliative care programs offer a holistic approach to care that puts patients and their families at the center of decision-making and control, where they belong.

NOTES

1 Centers for Disease Control and Prevention. Chronic Disease Overview. Available at: http://www.cdc.gov/nccd php/overview.htm.

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