Six Medical Centers Offer Training

Palliative Care *from page 1*

The fact that so many medical specialty boards came together to endorse the application attests to a consensus within medicine about the legitimacy of the field, Dr. Payne said. Demand for subspecialty certification is likely to be slow at first, he said, but should improve as physicians begin to understand that palliative medical skills complement neurological care.

The milestone is just the latest in a series of developments in the size and status of the field of palliative care. Between 2000 and 2004, the number of hospital-owned palliative care programs in the United States increased by nearly 75%, jumping from 632 in 2000 to 1,102 in 2004. As of 2004, 63% of large hospitals—those with at least 200 general adult beds—reported that they had some type of palliative care program, according to the Center to Advance Palliative Care.

This summer, palliative medicine received a nod from the Accreditation Council for Graduate Medical Education (ACGME) when the organization voted to approve an accreditation process for hospice and palliative medicine fellowship training programs. ACGME is expected to begin accepting applications in summer 2007.

"We're well beyond the tipping point," said Dr. Diane Meier, director of the Center to Advance Palliative Care and director of the Hertzberg Palliative Care Institute at Mount Sinai School of Medicine in New York. At her institution, palliative care has become so well accepted that asking for a palliative care consult is as routine as calling for an infectious disease consult. Physicians no longer see it as a personal failure in their treatment of the patient to get assistance from palliative care, she said. Now the focus has shifted from selling the concept of palliative medicine to ensuring that programs around the country have consistently high standards, Dr. Meier said.

The National Consensus Project for Quality Palliative Care, which is sponsored by three national palliative medicine organizations, has released quality guidelines. These guidelines include having interdisciplinary teams, making grief and bereavement services available to patients and families, and providing evidence-based pain and symptom relief, among others.

The standards are a guidepost but will be challenging for smaller programs, Dr. Meier said, and should be filtered by the size of the facility, the staff available, and the needs of the institution.

The National Quality Forum approved its own framework for palliative and hospice care earlier this year. "That's real legitimacy," Dr. Meier said.

In an effort to ensure that new programs have high-quality processes in place, the Center to Advance Palliative Care launched the Palliative Care Leadership Centers—six centers of excellence in palliative care around the country that train teams of health care providers. The program includes intensive, 2-day training sessions in which teams are sent to one of the six centers and leaders at the centers act as mentors for a year after training. The cost of the program is about $1,750 for a four-person team.

Close to 70% of the teams trained since 2004 have successfully established a program, said Dr. Meier. However, the process isn't fast, and it sometimes takes more than a year for teams to get their programs up and running, she said.

The Mount Carmel Health System in Columbus, Ohio, is one of the six leadership centers. The program was launched in 1997 in an effort to treat patients with serious, advanced diseases who were not candidates for hospice care, Mary Ann Gill, executive director of palliative care services at Mount Carmel, said. The Mount Carmel program, which includes a palliative care consult team and three dedicated palliative care units across three hospitals, is popular with teams working to start programs in community hospitals.

The training focuses on the clinical aspects of the program, as well as on financial management and how to sustain the program, Ms. Gill said.

While much of the interest in palliative medicine has been from physicians at mid-career, there is increasing interest among young physicians and residents, said Dr. Philip H. Santa-Emma, medical director for the palliative care service at Mount Carmel. "I've seen a huge increase in the number of residents coming through," he said.

But the training of new physicians in palliative care also represents one of the next big challenges in the field, Dr. Meier said. Currently there is a cap on the number of residency positions funded by Medicare, making it hard for a new subspecialty to gain a foothold, she said. Palliative care fellowships are currently funded by philanthropy. ■

Palliation Clinically Effective, Reduces Hospital Care Costs

BY MITCHEL L. ZOLER
Philadelphia Bureau

NASHVILLE, TENN. — Palliative care is clinically effective and is associated with lower hospitalization costs, according to an analysis of about 300 patients at one medical center.

In a subset of 104 patients who were hospitalized for more than 4 days and received palliative care, the total cost of hospital care averaged $209 per day less than the cost for another series of patients matched by age, diagnosis, and vital status at discharge, Dr. Laura C. Hanson and her associates reported in a poster at the annual meeting of the American Academy of Hospice and Palliative Medicine.

The cost savings were greater when palliative care was used for a longer period of time. In patients for whom palliative care was used for more than half the time hospitalized, the daily savings for total costs was $363, compared with matched controls, reported Dr. Hanson, a physician in the division of geriatrics at the University of North Carolina in Chapel Hill.

The analysis began with the 395 seriously ill patients who were referred to the inpatient, palliative care consult service at the University's hospital during 2002-2004. The study focused on 304 patients who consented to participate. Their mean age was 66 years, and 61% had cancer as their primary diagnosis. The top reasons for their referral were pain (57%), dyspnea (45%), and delirium (38%); percentages totaled more than 100%. End-of-life decision making was used for 88%; and 43% of the patients died during the index hospitalization.

At the time of patient referral, the mean symptom severity on the McCorkle symptom distress scale was 2.6 for pain, 2.3 for dyspnea, 2.2 for delirium, and 1.4 for nausea. These scores dropped steadily during the period of palliative care; after a week of care, the mean scores were 1.1 for pain, 1.0 for dyspnea, 1.0 for delirium, and 1.0 for nausea.

The average total cost of hospitalization for the 304 patients was $1,242 per day during the 20 days prior to the start of palliative care, and $753 per day during the 20 days after palliative care began, an estimated cost saving of $489 per day per patient.

A second economic analysis examined the total cost of hospitalization for several subsets of the patients treated with palliative care compared with matched series of patients who did not receive palliative care. Although the patients who received palliative care averaged longer lengths of stay in the hospital, they also had fewer days in the ICU and lower variable costs that led to overall cost savings.

In the subset of 104 patients who received palliative care for more than 4 days, the average total cost of care was $1,888 per day compared with an average of $2,097 per day for the control patients, a $209 per day difference. In the 66 patients who received palliative care for more than 25% of their days hospitalized, the average saving in total costs was $203 per day.

A final analysis looked at the costs for 55 patients who received palliative care and died while hospitalized, and compared these costs with the average cost during the final 10 days of hospitalization for a matched set of control patients. Once again, the average total costs per day were lower in the patients who received palliative care. ■